

recipients access to nursing facility services, and the quality of nursing facility care.

(e) Provisions of (3) pertaining to private pay limits do not apply to rate years beginning on or after July 1, 2001.

(f) The total payment rate available for the period July 1, 2001 through June 30, 2002 will be the rate as computed in (5), plus any additional amount computed in ARM 37.40.311.

(6) For providers who, as of July 1 of the rate year, have not filed with the department a cost report covering a period of at least 6 months participation in the medicaid program in a newly constructed facility shall have a rate set at the statewide median price as computed on July 1, 2001 for this transition year. Following a change in provider as defined in ARM 37.40.325, the per diem rate for the new provider shall be set at the previous provider's rate, as if no change in provider had occurred.

(7) For ICF/MR services provided by nursing facilities located within the state of Montana, the Montana medicaid program will pay a provider as provided in ARM 37.40.336.

(8) In addition to the per diem rate provided under (5) or the reimbursement allowed to an ICF/MR provider under (7), the Montana medicaid program will pay providers located within the state of Montana for separately billable items, in accordance with ARM 37.40.330.

(9) For nursing facility services, including ICF/MR services, provided by nursing facilities located outside the state of Montana, the Montana medicaid program will pay a provider only as provided in ARM 37.40.337.

(10) The Montana medicaid program will not pay any provider for items billable to residents under the provisions of ARM 37.40.331.

(11) Reimbursement for medicare co-insurance days will be as follows:

(a) for dually eligible medicaid and medicare individuals, reimbursement is limited to the per diem rate, as determined under (1) or ARM 37.40.336, or the medicare co-insurance rate, whichever is lower, minus the medicaid recipient's patient contribution; and

(b) for individuals whose medicare buy-in premium is being paid under the qualified medicare beneficiary (QMB) program under ARM 37.83.201 but are not otherwise medicaid eligible, payment will be made only under the QMB program at the medicare coinsurance rate.

(12) The department will not make any nursing facility per diem or other reimbursement payments for any patient day for which a resident is not admitted to a facility bed which is licensed and certified as provided in ARM 37.40.306 as a nursing

facility or skilled nursing facility bed.

(13) The department will not reimburse a nursing facility for any patient day for which another nursing facility is holding a bed under the provisions of ARM 37.40.338(1), unless the nursing facility seeking such payment has, prior to admission, notified the facility holding a bed that the resident has been admitted to another nursing facility. The nursing facility seeking such payment must maintain written documentation of such notification.

(14) Providers must bill for all services and supplies in accordance with the provisions of ARM 37.85.406. The department's fiscal agent will pay a provider on a monthly basis the amount determined under these rules upon receipt of an appropriate billing which reports the number of patient days of nursing facility services provided to authorized medicaid recipients during the billing period.

(a) Authorized medicaid recipients are those residents determined eligible for medicaid and authorized for nursing facility services as a result of the screening process described in ARM 37.40.101, 37.40.105, 37.40.106, 37.40.110, 37.40.120, and 37.40.201, et seq.

(15) Payments provided under this rule are subject to all limitations and cost settlement provisions specified in applicable laws, regulations, rules and policies. All payments or rights to payments under this rule are subject to recovery or non-payment, as specifically provided in these rules. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 685, Eff. 4/30/93; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1995 MAR p. 1227, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

37.40.308 RATE EFFECTIVE DATES (1) A provider's per diem rate effective for the rate period July 1, 2001 through June 30, 2002 shall be determined in accordance with ARM 37.40.307.

(2) Except as specifically provided in these rules, per diem rates and interim rates are set no more than once a year, effective July 1, and remain in effect at least through June 30 of the following year.

(a) Nothing in this subchapter shall be construed to require that the department apply any inflation adjustment, recalculate the median operating costs or the statewide median average wage, or otherwise adjust or recalculate per diem rates or interim rates on July 1 of a rate year, unless the department adopts further rules or rule amendments providing specifically

for a rate methodology for the rate year.

(i) A provider's per diem rate effective for the rate period July 1, 2000 through June 30, 2001 shall be determined in accordance with ARM 37.40.307.

(b) After the department has determined the median operating costs under ARM 37.40.313 and the statewide median average wage under ARM 37.40.314 for a rate year and has established provider rates based upon those determinations, the median operating costs and the statewide median average wage will not be revised or redetermined, except as provided in (1)(c), regardless of changes in provider costs resulting from base period cost report adjustments or other causes.

(c) The median operating costs under ARM 37.40.313 and the statewide median average wage under ARM 37.40.314 used to establish rates for a rate year will be redetermined only as required to set new rates for all providers for a subsequent rate year based upon adoption of further rules or amendments to these rules providing specifically for a rate methodology for a new or a subsequent rate year.

(3) A provider's rate established July 1 of the rate year shall remain in effect throughout the rate year and throughout subsequent rate years, regardless of any other provision in this subchapter, until the earlier of:

(a) the effective date of a new rate established in accordance with a new rule or amendment to these rules, adopted after the establishment of the current rate, which specifically provides a rate methodology for the new or subsequent rate year;

(b) the effective date of a change in the provider's operating cost component:

(i) as specified in the department's notice of final settlement of a cost report based upon a desk review or audit which results in adjustment of the base period operating costs used by the department to calculate the provider's operating cost component; or

(ii) as provided in ARM 37.40.326;

(c) the effective date of a change in the provider's direct nursing personnel cost component:

(i) as specified in the department's notice of final settlement of a cost report based upon a final desk review or audit which results in adjustment of the base period direct nursing personnel costs used by the department to calculate the provider's direct nursing personnel cost component; or

(ii) as provided in ARM 37.40.326; or

(d) the effective date of a change in the provider's property cost component:

(i) upon certification of newly constructed beds as provided in ARM 37.40.323(4);

(ii) upon completion of an extensive remodeling (as defined in ARM 37.40.302) as provided in ARM 37.40.323(5);

(iii) as specified in the department's notice of final settlement of a cost report based upon a final desk review or audit which results in adjustment of the base period property costs used by the department to calculate the provider's property cost component; or

(iv) as provided in ARM 37.40.326. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

Rules 09 and 10 reserved

37.40.311 RATE ADJUSTMENT FOR COUNTY FUNDED RURAL NURSING

FACILITIES (1) For state fiscal year 2002, and subject to the availability of sufficient county, state and federal funding, the department will provide a mechanism for a one time, lump sum payment during the last quarter of the state fiscal year, to non-state governmental owned or operated facilities for medicaid services. These payments will be for the purpose of maintaining access and viability for a class of "at risk" county affiliated facilities who are predominately rural and are the only nursing facility in their community or county or who provide a significant share of nursing facility services in their community or county.

(a) A nursing facility is eligible to participate in this lump sum payment distribution if it is a non-state governmental owned or operated facility.

(b) The department will calculate the amount of lump sum distribution that will be allowed for each county affiliated provider so that the total per day amount does not exceed the computed medicare upper payment limit for these providers. Distribution of these lump sum payments will be based on the medicaid utilization at each participating facility for the period July 1, 2001 through June 30, 2002.

(c) In order to qualify for this lump sum adjustment effective July 1, 2001, each non-state governmental owned or operated facility must enter into a written agreement to transfer local county funds to be used as matching funds by the department. This transfer option is voluntary, but those facilities that agree to participate must abide by the terms of the written agreement.

(2) Effective for the period commencing on or after July 1, 2001, and subject to the availability of sufficient county, state and federal funding, the department will provide for a one time,

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lump sum distribution of funding, during the last quarter of the state fiscal year, to nursing facilities not participating in the funding for "at risk" facilities for the provision of medicaid services.

(a) The department will calculate the maximum amount of the lump sum payments that will be allowed for each participating non-state governmental owned or operated facility, as well as the additional payments for other nursing facilities not participating in the funding for "at risk" facilities for the provision of medicaid services, based on the availability of funding and in accordance with state and federal laws, as well as applicable medicare upper payment limit thresholds. This payment will be computed as a per day add-on based upon the funding available. Distribution will be in the form of lump sum payments and will be based on the medicaid utilization at each participating facility for the period July 1, 2001 through June 30, 2002. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

Rule 12 reserved

37.40.313 OPERATING COST COMPONENT (1) This rule specifies the method used by the department to calculate the operating cost component for a specific provider. Such operating cost component is expressed in dollars and cents per patient day.

(a) Nothing in this rule shall be construed to provide for an automatic rate increase on July 1 of a new rate year. A provider's rate in effect immediately prior to July 1 of a new rate year shall remain in effect throughout the new rate year and subsequent rate years except as provided in ARM 37.40.308.

(2) As used in this rule, the following definitions apply:

(a) "Base period" means the provider's cost reporting period from which operating costs are determined and, if applicable, inflated for purposes of determining the operating cost component for a given year.

(i) Except as otherwise specified in ARM 37.40.326, for rate years beginning on or after July 1, 1999, the base period is the provider's cost report period of at least 6 months with a fiscal year ending between January 1, 1998 and December 31, 1998 inclusive, if available, or, if such a cost report has not been filed on or before April 1 preceding the rate year or is otherwise unavailable, the provider's most recent cost report period of at least 6 months on file with the department as of April 1 immediately preceding the rate year.

(b) "DRI-HC" means the DRI McGraw-Hill Health Care Costs: National Forecast Tables Nursing Home Market Basket published for the first calendar quarter of each year which projects inflation

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for the fourth quarter of the calendar year.

(c) "Inflated" means that the costs in question are indexed from the midpoint of the base period to the midpoint of the rate year, according to the DRI-HC. For the period July 1, 1999 through December 31, 1999, operating costs will be indexed at 75% of the DRI rate of inflation in order to offset the additional funding for the direct care wage add-on as provided in ARM 37.40.361 which is outside the per diem rate calculation. Regardless of any other provision of these rules, if base period costs are from the same period for which the rate is being set, such costs will not be inflated for purposes of this rule. Base period costs will not be inflated and a new rate will not be effective for a new rate year or a subsequent rate year except as provided in ARM 37.40.308.

(d) "Median operating costs" means the median amount calculated by arraying the inflated per diem base period operating cost of each provider from low to high, together with the number of licensed beds for the provider during the base period and determining the median so that one-half of the licensed beds in the array have per diem costs less than or equal to the median and one-half of the licensed beds in the array have per diem costs greater than or equal to the median.

(i) For purposes of setting rates for rate years beginning on or after July 1, 1992, if a provider has not filed a cost report for a period of at least 6 months with respect to the base period specified in (2)(a) for the rate year, such provider shall not be included in the array for purposes of calculating the median operating costs. A cost report which is not timely filed in accordance with ARM 37.40.346 as of April 1 immediately preceding the rate year shall not be considered filed for purposes of inclusion in the array.

(ii) In determining median operating costs for purposes of setting rates for rate years beginning on or after July 1, 1992, the inflated per diem base period operating cost shall be the inflated base period operating costs, not including reported nursing facility utilization fees paid or incurred pursuant to 15-60-102, MCA, plus the amount of the nursing facility utilization fee required by law to be paid for each bed day during the rate year.

(e) "Operating costs" means allowable patient-related administrative costs (including home office and management fees), dietary, laundry, housekeeping, plant operation, social services, activities, insurance and taxes, other than employment related insurance and taxes that are direct nursing personnel costs as defined in ARM 37.40.314, and all other allowable direct and indirect patient-related costs, subject to the provisions of ARM 37.40.345, which are not direct nursing personnel costs, as

defined in ARM 37.40.314, or property costs, as defined in ARM 37.40.323.

(i) For purposes of setting rates for rate years beginning on or after July 1, 1992, operating costs shall not include nursing facility utilization fees paid or incurred pursuant to 15-60-102, MCA.

(f) "Per diem operating costs" means the provider's total operating costs divided by the number of provider's patient days for the base period.

(3) The provider's operating cost component is the lesser of the provider's inflated base period per diem operating costs or the operating cost limit calculated in accordance with (4), plus an incentive allowance, if applicable, as provided in (5).

(a) In determining the provider's operating cost component for purposes of setting rates for rate years beginning on or after July 1, 1992, the inflated base period per diem operating cost shall be the inflated base period operating costs, not including reported nursing facility utilization fees paid or incurred pursuant to 15-60-102, MCA, plus the amount of the nursing facility utilization fee required by law to be paid for each bed day during the rate year.

(4) The operating cost limit is 99% of median operating costs.

(5) If the provider's inflated base period per diem operating cost is less than the operating cost limit calculated in accordance with (4), the provider's operating cost component shall include an incentive allowance equal to the lesser of 5% of median operating costs or 5% of the difference between the provider's inflated base year per diem operating cost and the operating cost limit.

(a) In determining the amount of any incentive allowance to which the provider may be entitled under (5) for purposes of setting rates for rate years beginning on or after July 1, 1992, the inflated base period per diem operating cost shall be the inflated base period operating costs, not including reported nursing facility utilization fees paid or incurred pursuant to 15-60-102, MCA, plus the amount of the nursing facility utilization fee required by law to be paid for each bed day during the rate year. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 685, Eff. 4/30/93; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 1044, Eff. 6/24/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489.)

37.40.314 DIRECT NURSING PERSONNEL COST COMPONENT

(1) This rule specifies the method used by the department to calculate the direct nursing personnel cost component for a specific provider. Such nursing cost component is expressed in dollars and cents per patient day.

(a) Nothing in this rule shall be construed to provide for an automatic rate increase on July 1 of a new rate year. A provider's rate in effect immediately prior to July 1 of a new rate year shall remain in effect throughout the new rate year and subsequent rate years except as provided in ARM 37.40.308.

(2) As used in this rule, the following definitions apply:

(a) "Base period" means the provider's same cost reporting period from which operating costs are determined and, if applicable, inflated for purposes of determining the providers operating cost component for a given year.

(i) Except as otherwise specified in ARM 37.40.326, for rate years beginning on or after July 1, 1999, the base period is the provider's cost report period of at least 6 months with a fiscal year ending between January 1, 1998 and December 31, 1998 inclusive, if available, or, if such a cost report has not been filed on or before April 1 preceding the rate year or is otherwise unavailable, the provider's most recent cost report period of at least 6 months on file with the department as of April 1 immediately preceding the rate year.

(b) "Composite nursing wage rate" means the total base period direct nursing personnel cost divided by the product of the providers fiscal year 1999 average patient assessment score and the provider's patient days for the base period.

(i) For purposes of calculating the composite nursing wage rate, the provider's base period average patient assessment score is the fiscal year 1999 average patient assessment score that was previously determined by the department in accordance with rules in effect for that period.

(c) "Direct nursing personnel cost" means allowable direct nursing personnel wages, salaries and benefits, to the extent such are direct costs of patient-related services actually rendered within the facility and are separately identifiable, rather than merely allocable, as such. Direct nursing personnel costs include the accrued wages, salaries and benefits of direct nursing personnel, to the extent such wages, salaries and benefits meet the other requirements of this definition and subject to the provisions of ARM 37.40.345. For purposes of this subchapter, direct nursing personnel include only registered nurses, licensed practical nurses, nurse aides, and, to the extent engaged in actual patient care rather than nursing administration, the director of nursing.

(d) "DRI-HC" means the DRI McGraw-Hill Health Care Costs: National Forecast Tables Nursing Home Market Basket published for the first calendar quarter of each year which projects inflation for the fourth quarter of the calendar year.

(e) "Inflated" means that the costs in question are indexed from the midpoint of the base period to the midpoint of the rate year, according to the DRI-HC. Direct nursing costs will not be indexed by the DRI rate of inflation for the period July 1, 1999 through December 31, 1999 to offset the additional funding for the direct care wage add-on as provided in ARM 37.40.361 which is outside the per diem rate calculation. Regardless of any other provision of these rules, if base period costs are from the same period for which the rate is being set, such costs will not be inflated for purposes of this rule. Base period costs will not be inflated and a new rate will not be effective for a new rate year or a subsequent rate year except as provided in ARM 37.40.308.

(f) "Statewide median average wage" means the amount calculated by arraying the inflated base period average wage rate for each provider from low to high, together with the number of licensed beds for the provider during the base period and determining the median so that one-half of the licensed beds in the array have average wage rates less than or equal to the median and one-half of the licensed beds in the array have average wage rates greater than or equal to the median.

(i) For purposes of setting rates for rate years beginning on or after July 1, 1992, if a provider has not filed a cost report for a period of at least 6 months with respect to the base period specified in (2)(a) for the rate year, such provider shall not be included in the array for purposes of calculating the statewide median average wage. A cost report which is not timely filed in accordance with ARM 37.40.346 as of April 1 immediately preceding the rate year shall not be considered filed for purposes of inclusion in the array.

(3) The provider's direct nursing personnel cost component is the lesser of the provider's inflated base period composite nursing wage rate multiplied by the provider's fiscal year 1999 average patient assessment score or the direct nursing personnel cost limit calculated in accordance with (4).

(4) The direct nursing personnel cost limit is 99% of the statewide median average wage, multiplied by the provider's 1999 average patient assessment score, determined in accordance with the rules in effect for that period. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD,

1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 1044, Eff. 6/24/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489.)

37.40.315 PATIENT ASSESSMENT, STAFFING AND REPORTING

(1) For purposes of determining rate year 2000 rates, the provider's average patient assessment score will be the patient assessment score that was established for fiscal year 1999 rate setting proposes in accordance with the rules in effect during that period.

(2) Providers must provide staffing at levels which are adequate to meet federal law, regulations and requirements.

(a) Each provider must submit to the department within 10 days following the end of each calendar month a complete and accurate form DPHHS-SLTC-015, "Monthly Nursing Home Staffing Report" prepared in accordance with all applicable department rules and instructions. Copies of form DPHHS-SLTC-015 may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(b) If complete and accurate copies of form DPHHS-SLTC-015 are not received by the department within 10 days following the end of each calendar month, the department may withhold all payments for nursing facility services until the provider complies with the reporting requirements in (1)(a). (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-108, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

Rules 16 through 19 reserved

37.40.320 MINIMUM DATA SET SUBMISSION, TREATMENT OF DELAYS IN SUBMISSION, INCOMPLETE ASSESSMENTS, AND CASE MIX INDEX CALCULATION

(1) Nursing facilities shall submit all minimum data set assessments and tracking documents to the health care financing administration (HCFA) database as required by federal participation requirements, laws and regulations.

(2) Submitted assessment data shall conform to federal data specifications and meet minimum editing and validation requirements.

(3) Retention of assessments on the database will follow the records retention policy of the department of public health and human services. Back up tapes of each rate setting period will be maintained for a period of 5 years.

(4) Assessments not containing sufficient in-range data to

perform a resource utilization group-III (RUG-III) algorithm will not be included in the case mix calculation during the transition period.

(5) All current assessments in the database older than 6 months will be excluded from the case mix index calculation.

(6) For purposes of calculating rates, the department will use the RUG-III, 34 category, index maximizer model, version 5.12. The department may update the classification methodology to reflect advances in resident assessment or classification subject to federal requirements.

(7) For purposes of calculating rates, case mix weights will be developed for each of the 34 RUG-III groupings. The department will compute a Montana specific medicaid case mix utilizing average nursing times from the 1995 and the 1997 HCFA case mix time study. The average minutes per day per resident will be adjusted by Montana specific salary ratios determined by utilizing the licensed to non-licensed ratio spreadsheet information.

(8) For purposes of calculating rates, the department shall assign each resident a RUG-III group calculated on the most current non-delinquent assessment available on the first day of the second month of each quarter as amended during the correction period. The RUG-III group will be translated to the appropriate case mix index or weight. From the individual case mix weights for the applicable quarter, the department shall determine a simple facility average case mix index, carried to four decimal places, based on all resident case mix indices. For each quarter, the department shall calculate a medicaid average case mix index, carried to four decimal places, based on all residents for whom medicaid is reported as the per diem payor source any time during the 30 days prior to their current assessment.

(9) Facilities will be required to comply with the data submission requirements specified in this rule and ARM 37.40.321 during the rate year beginning July 1, 1999 for the development of a case mix reimbursement system. The department will utilize medicaid case mix data in the computation of rates for the period July 1, 2001 through June 30, 2002. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

37.40.321 CORRECTION OF ERRONEOUS OR MISSING DATA

(1) The department will prepare and distribute resident listings to facilities by the 15th day of the 3rd month of each quarter (cut off date). The listings will identify current assessments for residents in the nursing facility on the 1st day of the 2nd month of each quarter as reflected in the database maintained by the department. The listings will identify

resident social security numbers, names, assessment reference date, the calculated RUG-III category and the payor source. Resident listings shall be signed and returned to the department by the 15th day of the 1st month of the following calendar quarter. Facilities who do not return this corrected resident listing by the due date will use the database information on file in their case mix calculation.

(2) If data reported on the resident listings is in error or if there is missing data, facilities will have until the 15th day of the 1st month of each calendar quarter to correct data submissions.

(a) Errors or missing data on the resident listings due to untimely submissions to the HCFA database maintained by the department of public health and human services (DPHHS) are corrected by transmitting the appropriate assessments or tracking documents to DPHHS in accordance with HCFA requirements.

(b) Errors in key field items are corrected following the HCFA key field specifications through DPHHS.

(c) Errors on the current payor source should be noted on the resident listings prior to signing and returning to DPHHS.

(3) The department may also use medicaid paid claim data to determine the medicaid residents in each facility when determining the medicaid average case mix index for each facility. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

37.40.322 OBRA COST REIMBURSEMENT (1) For rate years beginning on or after July 1, 1992, OBRA costs will be reimbursed under the per diem rate determined under ARM 37.40.307. No further reimbursement will be provided for such costs except as specifically provided in these rules.

(2) Each provider must document and submit to the department on a quarterly basis information on the nurse aide certification training and competency evaluation (testing) costs, including but not limited to the costs of training for nurse aides and the costs of actual testing required for nurse aides, incurred at the facility and, in the case of competency evaluation (testing) costs for providers that are not testing entities, incurred in payment of a qualified testing entity's fee for competency evaluation (testing). The required information must be submitted quarterly on the nurse aide certification/training and competency evaluation (testing) survey reporting form provided by the department and must include the total dollars incurred in each of the categories of facility personnel, supplies and equipment, subcontracted services and

testing fees. The reporting form must include a brief description of the items included in each of the four categories.

(a) Acceptable documentation will be any documentation that adequately supports the costs claimed on the reporting form and includes all records and documentation as defined in ARM 37.40.346, such as invoices, contracts, canceled checks and time cards. This documentation is subject to desk review and audit in accordance with ARM 37.40.346. This documentation must be maintained by the facility for 6 years, 3 months from the date the form is filed with the department or until any dispute or litigation regarding the costs supported by such documentation is finally resolved, whichever is later.

(b) If a provider fails to submit the quarterly reporting form within 30 calendar days following the end of the quarter, the department may withhold reimbursement payments in accordance with ARM 37.40.346(4)(c). All amounts so withheld will be payable to the provider upon submission of a complete and accurate nurse aide certification/training survey reporting form.

(3) For periods beginning on or after April 1, 1992, medicaid nursing facility reimbursement for the costs associated with training and competency evaluation programs for nurse aides employed in medicare and medicaid nursing facilities, as required under the Omnibus Budget Reconciliation Act of 1987 (OBRA), shall be as follows:

(a) Nurse aide certification training and competency evaluation (testing) costs documented in accordance with (2) and allowable under ARM 37.40.345 will be reimbursed to the extent provided under the per diem rate determined under ARM 37.40.307. No further reimbursement will be provided for such costs.

(4) For purposes of reporting under (2), nurse aide tests are those tests which:

(a) demonstrate competency through testing methods which address each course requirement and include successful completion of both a written or oral examination and a demonstration of the skills required to perform the tasks required of a nurse aide;

(b) are performed at either a nursing facility which is currently in compliance with medicaid nursing facility participation requirements or at a regional testing site at regularly scheduled testing times;

(c) are administered to nurse aides actually employed by the facility; and

(d) do not exceed a third attempt by the individual nurse aide to successfully complete the portion of the test for which costs are reported. The written/oral examination and the skills demonstration may be taken separately if the nurse aide passed only one portion of the test in a previous exam.

(5) Competency evaluation (testing) costs reported by a